Results

	Group 1 N=30	Group 2 N=30	Value of P
Average age (years)	44.5±4,2	56,7±6,3	<0,01
Smoking	67%	64%	NS
Dyslipidemy	50%	27%	0,01
Diabetes	37%	39%	NS
Hypertension	13%	22%	0,01
Inaugural MI	83%	34%	<0.001
MI occuring at rest	97%	57%	<0.001
Anterior topography	70%	55%	<0.05
MI none Q	37%	17%	0.01
Normal TTE	27%	15%	<0.01
Dilatation of LV	3%	48%	<0.001

LV: left ventricle

The coronarography was realized in 10 cases of group 1 and 14 of group 2. It visualized especially impairment mono tronculaire in group 1, by cons multitronculaires injuries are frequently encountered in group 2.The hospital mortality was lower in young compared with older subjects.

Conclusion: The MI of the young subject is inaugural in the majority of cases and occurs especially at rest. Smoking and dyslipidemy are the independent factors of risk. The coronary lesions are non significant or readily mono tronculaires.

081

Acute coronary syndrome in patients with diabetes: comparative series of 202 patients with and 250 patients without diabetes

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Introduction: Acute coronary syndrome (ACS) is common in diabetics and severe, the severity of coronary lesions and multiplying cardiovascular risk are likely to role in this adverse trend.

Objectives: The aim of this study was to determine the clinical and angiographic characteristics, treatment and development of ACS in diabetics (D) compared to nondiabetic (ND).

Methods: From January 2010 through April 2011, 452 patients with ACS were hospitalized in the cardiology department of the CHU Ibn Rochd in Casablanca Morocco, they included 202 D and 250 ND.

Results: Comparison of these two groups showed a younger age with a mean age of 51.4 years and a higher percentage of men (59%) among the D, hypertension was more frequent in D, while smoking was frequent in both groups.

Hospitalization was the reason for ACS without ST segment elevation in 54.3% in the D group versus 43.8% in the ND group (p=0.03) and for ACS with persistent ST segment elevation in 45.6% in the D group versus 56,1% in the ND group (p=0,02).

Coronary angiography showed: Table I

Table I – results of coronary angiography

	Diabetic patients	Nondiabetic patients	p value
normal coronary angiogram	13%	28%	0.002
single vessel coronary diseases	24%	42%	0.008
two-vessel coronary disease	27%	19%	0.15
multivessel coronary artery disease	35%	11%	0.00001
long coronary disease	69%	28%	0.0001
distal coronary disease	41%	19%	0.0001
anterior interventricular artery disease	49%	54%	0.449
left circumflex artery disease	19%	20%	0.9
right coronary artery disease	32%	26%	0.34

The syntax score calculated in the D was above 33 in 38.5% versus 11.4% in the ND, treatment was similar in both groups, 209 patients underwent myocardial revascularization, and its method (thrombolysis or coronary angioplasty or coronary artery bypass graft) did not differ by group. Neither hospital mortality nor other complications differed between the two groups.

Conclusion. The ACS in diabetics occurs at a younger age with a male predominance, coronary lesions are more extensive, more severe, often multivessel and distal.

Correct management of ACS and close collaboration between cardiologists and endocrinologists should improve prognosis for patients with diabetes.

082

Primary angioplasty versus thrombolysis in ST elevation myocardial infarction

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Introduction: the treatment of ST segment elevation myocardial infarction is to restore permeability of the responsible coronary artery; the goal of our work is to illustrate the benefit of primary angioplasty as an alternative to thrombolysis.

Materials and methods: This is a retrospective study concerning 75 patients admitted for ST segment elevation myocardial infarction, between January 2008 and February 2010, divided into 2 groups: group [1] n=30, treated by primary angioplasty, compared to the group [2] n=45 thrombolysed.

Results: the average age of our patients is 56.6 ± 6.7 years (group 1) and 55.4 ± 5.9 years (group 2), male is predominant in the 2 groups, most of patients had more than 2 cardiovascular risk factors in the 2 groups.

The time between chest pain and admission to the emergency department is 231min in group 1 versus 247min in group 2, and the period of reperfusion is 281 min in group 1 (door to baloon) versus 277min (onset of chest pain to thrombolysis).

The coronary angiography showed three vessel lesions in 30% [group 1] versus 26% [Group 2], two vessel lesions in 23% [group 1] versus 18% [Group 2] and a single-vessel-disease in 47% [group 1] versus 56% [group 2].

In group 1, in addition to medical treatment and primary angioplasty, 3.3% had undergone coronary artery bypass grafting, in group 2, after thrombolysis, 24% benefited from angioplasty, 20% had CABG and 56% was treated medically.

Primary angioplasty has been marked by a primary success, the outcome was good in 83%, stent thrombosis occurred only in 2 cases.

In the second group, the outcome was favourable in only 46%, we deployed a single death due to cardiogenic shock and complications like left ventricular dysfunction in 13%, angina in 13% and arrhythmia in 3%.

Conclusion: the choice of basic therapy in STEMI is mainly based not only on accessibility to the angiography room but on angioplasty reperfusion (door to balloon), as well, when it is available, the angioplasty is highly recommended.